RESET

STATE OF TENNESSEE GROUP INSURANCE PROGRAM

APPLICATION FOR MEDICARE SUPPLEMENT PLAN 3 (NON-TCRS)

State of Tennessee • Department of Finance and Administration • Division of Insurance Administration
13th Floor, William R. Snodgrass TN Tower • Nashville, Tennessee 37243 • 615.741.3590/1.800.253.9981 • Fax: 615.741.8196

ENROLLMENT INFORMATION

Check One: ❑ State Plan ❑ Local Education Plan ❑ Local Government Plan

Last Name	First Name	MI	Social Security Number

Street Address	City	State	Zip

Phone	Birthdate	❑ Male ❑ Female

Marital Status: ❑ Single ❑ Divorced ❑ Married ❑ Widowed

Coverage Requested: ❑ Individual ❑ Dependent Only ❑ Retiree + one or more dependents

Family members to be covered by your contract. See reverse side for code listing.

Social Security #	Legal Name Last, First, MI	Birthdate mm/dd/yy	Relationship Code	Sex	Acquire Date mm/dd/yy	Student (19-24)	Marital Status	Medicare Eligible
				❑ M ❑ F		❑ Y ❑ N		❑ Y ❑ N
				❑ M ❑ F		❑ Y ❑ N		❑ Y ❑ N
				❑ M ❑ F		❑ Y ❑ N		❑ Y ❑ N
				❑ M ❑ F		❑ Y ❑ N		❑ Y ❑ N

Are you or your spouse presently eligible for Part A of Medicare?

Retiree ❑ Yes Date Effective _____
❑ No Date Eligible _____

Spouse ❑ Yes Date Effective _____
❑ No Date Eligible _____

Are you or your spouse presently eligible for Part B of Medicare?

Retiree ❑ Yes Date Effective _____
❑ No Date Eligible _____

Spouse ❑ Yes Date Effective _____
❑ No Date Eligible _____

Are you, your spouse or dependents receiving Social Security benefits ***based on disability?***

Retiree ❑ Yes ❑ No Date Eligible _____ Enrolled in Part B Medicare? ❑ Yes ❑ No

Spouse ❑ Yes ❑ No Date Eligible _____ Enrolled in Part B Medicare? ❑ Yes ❑ No

Dependent Name _____ Date Eligible _____ Enrolled in Part B Medicare? ❑ Yes ❑ No

Dependent Name _____ Date Eligible _____ Enrolled in Part B Medicare? ❑ Yes ❑ No

You must attach a copy of Medicare card.

OTHER INSURANCE INFORMATION

Are you or a family member covered by a group health insurance company or the holder of another health care coverage? ❑ Yes ❑ No
If yes, please furnish the following:

First Name of Insured	Place of Employment
Relationship to Insured ❑ Self ❑ Spouse ❑ Dependent	Insurance Company
ID or Policy Number (if known)	Insurance Company Address (if known)

AUTHORIZATION

I confirm that all of the information provided is accurate. I authorize health care providers to furnish the insurance carrier with all medical, admission and insurance records pertaining to me and my dependents. I understand that if my dependents become ineligible for coverate that I must report the change to my retirement plan within five working days. I understand that all claims paid for ineligible dependents must be repaid to the plan by me. I have submitted proof of being enrolled in Medicare Part A and Part B.

Signature	Date

EMPLOYER CERTIFICATION — NEW ELIGIBLE REIREES ONLY

This in no way obligates an employer to pay any portion of a retiree's premium.

Does the agency pay any portion of the premium? ❑ Yes ❑ No	Type of coverage maintaned by employee: ❑ Single ❑ Family	
Date employee began employment with agency (for retirement purposes) as verified by employment records.		Total months of service
Date employee was first covered under the agency group health plan.	Date coverage will be terminated through employer.	
Agency Name	Phone Number	Retiree Budget Code
Signature of Certifying Officer	Title	

DEPENDENT CODES

Dependent children between the ages of 19 and 24 may be covered only if they continue to meet eligibility guidelines and were covered at the time of the employee's retirement. In the event of a retiree's death, a covered spouse or dependent not yet eligible for Medicare will receive six months of free insurance coverage. Newly acquired dependents must be added to the plan within 60 days. A social security number must be provided for any dependent two years of age or older.

RELATIONSHIP CODES		ACQUIRE DATE
SP	Legally married spouse	Date of marriage
CN	Natural child	Date of birth
CN	Legally adopted child	Date of intention to adopt
CS	Stepchild for whom you or your spouse has legal or joint custody	Date custody obtained or marriage date
CL	Any child for whom you are the legal guardian	Date appointed guardian
CT	Any child you claim as a dependent for federal income tax.	Date you were able to claim child

IMPORTANT: It is your responsibility to notify your retirement plan of any changes in the eligibility status of a dependent within five working days.

The following are not eligible for coverage as your dependent through the state group insurance program:

- Ex-spouse (even if court ordered)
- Parents of the employee or spouse
- Children in the armed forces on a full time basis
- Children over age 24 (unless they meet the qualifications for incapacitation)
- Married children, regardless of age
- Foster children
- Live-in companions not legally married to the employee

Acquire Dates are needed solely for the purposes of determining the date of eligibility.

STUDENT: Check Yes or No for any unmarried dependent child older than 18 years and 11 months of age. A full-time student is one who is registered for at least the number of credit hours that an accredited (licensed) school, college, or university requires in its definition of full-time student status and who attends classes for two of three semesters or three of four quarters in any 12-month period.

A complete explanation of dependent eligibility is found in the Insurance Handbook available from your agency personnel office. Please contact your agency's insurance preparer with any questions concerning this form.